FAX /INCIDENT REPORT

State Form 50761 (12-01)

FACILITY NAME:_____

FACILITY ADDRESS:_____

_____

REPORTED BY:_____**TITLE:**_____

INCIDENT DATE:_____**INCIDENT TIME:**_____

RESIDENTS INVOLVED

NAME OF RESIDENT	**ROOM #**	**AGE**
1._____	_____	_____

DIAGNOSIS_____

_____

2._____	_____	_____

DIAGNOSIS_____

_____

STAFF INVOLVED

NAME OF STAFF PERSON	**TITLE**
1._____	_____
2._____	_____
3._____	_____

1. BRIEF DESCRIPTION OF INCIDENT

_____

_____

_____

_____

_____

*****PLEASE ANSWER ALL QUESTIONS ON THE SECOND PAGE*****

BRIEF DESCRIPTION OF INCIDENT (CONT.)

_____

_____

_____

_____

_____

2. TYPE OF INJURY/INJURIES

_____

_____

3. IMMEDIATE ACTION TAKEN

_____

_____

4. PREVENTIVE MEASURES TAKEN

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